42 CFR 440.90

CLINIC SERVICES (Limitations continued)

5. Maternal and Child Health (Title V Grantee) Clinics

a. Maternal and Child Health Clinic services are covered benefits for EPSDT eligibles.

b. Qualified providers include clinics under the direction of a licensed physician and operated or administered by the Title V grantee agency.

c. The clinic scope of benefits includes preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services, including early intervention services, provided by or under the direction of a licensed physician or dentist. Other providers of services include registered nurses, psychologists, dieticians, clinical social workers, audiologists, speech and language pathologists, occupational therapists, or physical therapists practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing (Utah Code Annotated, as amended 1953).

d. All clinic services are provided under the direction of a physician according to a written plan of care that is reviewed periodically by the directing physician.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

a. that the proposed services are medically appropriate, and

b. that the proposed services are more cost effective than alternative services.

DENTAL SERVICES

42 CFR 440.100

SERVICE

Dental service includes diagnostic, preventive, and restorative procedures.

LIMITATIONS

1. Dental services are limited to those services for the prevention and abatement of decay and restoration of dental health.

   Excluded services include:

   a. Orthodontics or surgery for orthodontic purposes;

   b. Fixed bridges, osseo-implants, sub-periosteal implants, ridge augmentation, transplants, or replants;

   c. Pontic services, vestibuloplasty, occlusal appliances, or osteotomies;

   d. Study models or diagnostic casts;

   e. Treatment of temporomandibular joint syndrome, its prevention or sequelae, subluxation, therapy, arthrotomy, meniscectomy, or condylectomy;

   f. Dental examination or prophylaxis performed more frequently than twice per calendar year by a provider for a client.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

42 CFR 440.110 PHYSICAL THERAPY SERVICES

LIMITATIONS

1. Physical therapy services will be provided for rehabilitation only. Therapy for the purpose of maintenance is not a covered Medicaid benefit. Physical therapy service must be based on physician order, follow a written plan of care, and be specific for the patient's diagnosis.

2. Physical therapy for stroke patients must be initiated within sixty (60) days following the stroke, and may continue only until the expected reasonable level of function is restored.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

42 CFR 440.110

OCCUPATIONAL THERAPY SERVICES

LIMITATIONS

Occupational therapy services will be provided for rehabilitation only. Therapy for the purpose of maintenance is not a covered Medicaid benefit. Occupational therapy service must be based on physician order, follow a written plan of care, and be specific for the patient's diagnosis.

Occupational therapy is limited to the following diagnoses: traumatic brain injury, spinal cord injury, hand injury, cerebral vascular accident (CVA), congenital anomalies or developmental disabilities causing neurodevelopmental deficits.

Occupational therapy for CVA patients must be initiated within 90 days following the stroke, and may continue only until the expected, reasonable level of function is restored.

42 CFR 440.110 SPEECH PATHOLOGY SERVICES

LIMITATIONS

1. One speech evaluation per client per year is a covered service. More than one speech evaluation per client per year is not a covered service.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

42 CFR 440.110 AUDIOLOGY

LIMITATIONS

The following services are excluded from coverage:

1. Hearing aids that are not guaranteed by the manufacturer for one year or more;

2. Charges for the return of a hearing aid (within 60 days) when the physician or audiologist determines that the aid does not meet specifications, and request a change;

3. Separate charges for initial ear mold, fitting, conformity evaluation, testing batteries, and instructing recipients.

4. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

42 CFR 440.120 PRESCRIBED DRUG SERVICES

LIMITATIONS

1. Drug Efficacy Study Implementation Project Drugs (DESI Drugs) as determined by the FDA to be less than effective are not a benefit of the Medicaid program.

   Other drugs and/or categories of drugs as determined by the Utah State Division of Health Care Financing and listed in the Pharmacy Provider Manual are not a benefit of the Medicaid program.

2. Generally equivalent drugs, approved by the FDA and listed in the Pharmacy Provider Manual, are a benefit of the Medicaid program.

3. Over-the-counter (OTC) drugs are limited to those drugs approved for use upon the recommendation of the Utah State Division of Health Care Financing and listed in the Pharmacy Provider Manual.

4. Immunosuppressive drugs will be limited to use with covered transplants.

5. The Division shall impose a copayment for each prescription filled when a non-exempt Medicaid client, as described on his Medicaid card, receives the prescribed medication. The Division shall limit the out-of-pocket monthly expense of the Medicaid client. These amounts are designated in R414-60 UAC.

   a. The Division shall deduct the copay amount from the reimbursement paid to the provider, up to the monthly maximum.

   b. The provider should collect the copayment amount from the Medicaid client for those prescriptions requiring a copayment.

   c. There are categories of Medicaid clients who are exempt from the copayment requirement, as designated in R414-60 UAC.

   d. Pharmaceuticals prescribed for family planning purposes are exempt from the copayment requirement.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternate services.

DENTURE SERVICES

42 CFR 440.120

SERVICE

Denture service refers to the fabrication and placement of a complete or partial denture in either arch.

Initial placement includes the relining to assure the desired fit.

LIMITATION

None.

42 CFR
440.120

PROSTHETIC DEVICES

Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law to:

1. artificially replace a missing portion of the body;

2. prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning); or

3. support a weak or deformed portion of the body.

LIMITATIONS

The following services are excluded from coverage as a benefit of the Medicaid program:

1. Shoes, orthopedic shoes, or other supportive devices for the feet, except when shoes are integral parts of leg braces or a prosthesis.

2. Shoe repair, except as it relates to external modification of an existing shoe, to meet a medical need, e.g., leg length discrepancy requiring a shoe "build-up" of one inch or more.

3. Personal comfort items and services. Comfort items include, but are not limited to, arch supports, foot pads, "cookies" or accessories, shoes for comfort, or athletic shoes.

4. Manufacture, dispensing, or services related to orthotics of the feet.

5. Internal modification of a shoe, except when supported by documentation of medical necessity.

6. The Agency nay exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

42 CFR
440.120

PROSTHETIC AND ORTHOTIC DEVICES
(BRACES, ARTIFICIAL LIMBS, AND/OR PARENTERAL/ENTERAL SUPPLIES

Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law to:

1. artificially replace a missing portion of the body;

2. prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning); or

3 support a weak or deformed portion of the body.

LIMITATIONS

The following items are excluded from coverage as benefits of the Medicaid program:

1. Any support item that could be classified as a corset, even those that have metal or wire supports;

2. "Test" equipment;

3. Any item provided to nursing home recipients that has been specifically restricted in the index in the Medical Supplies Provider Manual;

4. The providing of two monaural hearing aids instead if one binaural aid;

5. Rental of a hearing aid in excess of three months;

6. Nutrients used as food supplements. They are a Medicaid benefit only as total nutrition;

7. Baby formulas such as Similac, Enfamil, or Mull-soy.

8. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.